School Sealant Program

Dental Consent Form

Your child's school has been selected to participate in the Kansas School Sealant Program. Dental Professionals will be offering services in your child's school such as: sealants, fluoride varnish, and/or cleanings. If you already have a dental home please continue to see your dentist for regular cleanings and check-ups!

School Name_____ City_____

Student Name_____ Date of Birth_____ Age_____ Gender: ☐ Male ☐ Female

Race/ Ethnicity (check all that apply)				
	☐ White	☐ Asian	☐ American Indian/Alaska Native	☐ Other
	☐ Black/African American	☐ Hispanic	☐ Native Hawaiian/Pacific Islander	

Parent/Guardian Name_____ Daytime phone_____

Parent/Guardian Address_____ City_____ State____ Zip_____

The State of Kansas and the Dental Professionals administering this program are dedicated to improving your child's oral health by offering outreach dental services. After your child is treated, you will receive a report stating what services were provided along with a dental referral if needed.

The information from my child's participation in this special event will be utilized anonymously for statistical purposes and information that identifies my child or family will never be disclosed in any form or publication.

If offered, please check all services that your child may receive:

☐ Sealants (if indicated)	☐ Fluoride Treatment	☐ Dental Cleaning

I give (Sealant Site) permission to provide preventative dental services for my child and to collect payment from Medicaid, Health Wave or private insurance. (select all that apply)

☐ Medicaid # _____ ☐ No Insurance _____

☐ Health Wave # _____ ☐ Eligible for free/reduced lunch Program

☐ Insurance Name_____ Group # _____ Primary Subscriber Name_____

Mailing address for claims_____

_____

Parent/Guardian Signature_____ **Date**_____

Kansas Department of Health and Environment

Kansas Bureau of Oral Health

School Sealant Program

Medical History

Student Name: _____ Date of Birth: ____/____/____

School_____ Teacher_____ Grade_____

When did your child last visit a dentist? ☐In the past year ☐ More than a year ☐ Never

Why did your child visit the dentist?

☐Cleaning/checkup ☐Toothache ☐ Filling ☐Tooth pulled ☐Other

Medical History: Check all that apply

☐ Artificial Heart Valve ☐Artificial Joints Pins/Screws ☐Asthma ☐Congenital Heart Disorder

☐Diabetes ☐Heart Disease ☐Hepatitis ☐Seizure disorder

☐Heart murmur ☐Autism ☐Other_____

Any Known Allergies: ☐Latex ☐Amoxicillin/Penicillin ☐Other_____

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment? ☐No ☐Yes

- If yes, for what condition_____

Does your child have Special Health Care Needs ? ☐No ☐Yes

Surgeries/Hospitalizations/Other Medical Conditions: _____

_____

Medications your child is currently taking? _____

_____

Other information- Please tell us anything you think we should know about your child's health or previous dental experiences that would help us treat your child or meet their needs._____

_____

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

(Program Name) will treat all patient information as protected health information (PHI) under HIPPA regulations, exchanging the PHI only with personnel employed by (Program Name) and the facility/school who are responsible for medical treatment and/or record review.

Parent/Guardian Signature_____ Date_____

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